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ABSTRACT

Title XI of the Elementary and Secondary Education Act as amended by the Improving America's Schools Act of 1994 allows the Dallas (Texas) public schools to redirect up to 5% of each appropriation received through the Act for the purpose of providing a comprehensive approach to meeting the educational, health, social service, and other needs of children and families. As a result, nine Youth and Family Centers were opened. Each provided coordinated, integrated physical health, mental health, and other support services. In all, 3,407 students received services, for a total of 3,686 physical health visits and 2,677 mental health visits. In addition, 1,485 visits were for support services. Results of the questionnaire completed by 75 principals were positive and showed that principals felt that centers provided quality services, had a positive reputation, and were valuable to the students. Responses to the Family Satisfaction Questionnaire from 273 parents were strongly positive and showed that families were pleased with services, staff, and knowledge they had gained. Students referred to the Youth and Family Centers had fewer discipline referrals, course failures, absences, and nurse visits in the school year. Although these results were statistically significant, they were not of practical significance. Results on the Texas Assessment of Academic Skills improved, but results from the Iowa Tests of Basic Skills did not. When the district's Student Effectiveness Indices were calculated and concomitant variables were controlled, students were at expectations on both standardized tests. (Contains 11 tables and 10 references.) (Author/SLD)

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Youth and Family Centers: Evaluation of an Integrated School-Based Health Care Program

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Paper presented at the annual meeting of the Southwest Education Research Association, January 23-25, 1997 in Austin, Texas.

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Abstract

Through Title XI, P.L.-103-382 of the Elementary and Secondary Education Act, as amended by the Improving America's Schools Act of 1994, the Dallas Public Schools could redirect up to 5% of each appropriation received through the Act for the purpose of providing a comprehensive approach to meeting the educational, health, social service, and other needs of children and their families. As a result, nine Youth and Family Centers were opened. Each center provided coordinated, integrated physical health, mental health, and other support services. In all, 3,407 students received services. A total of 3,686 physical health visits and 2,677 mental health visits were logged. Additionally, 1,485 received support services. Results of the principal questionnaire were positive and showed that principals felt that the centers provided quality services, had a positive reputation, and were valuable to the students. Responses to the Family Satisfaction Questionnaire were strongly positive and showed that families were pleased with the services, staff, and knowledge that they had gained related to their problems. Students referred to the Youth and Family Centers had fewer discipline referrals, course failures, absences, and nurse visits from the beginning to the end of the school year. Although results were statistically significant, they were not of practical significance. Results of standardized tests showed improvement on the Texas Assessment of Academic Skills (TAAS), but negative gains on the Iowa Test of Basic Skills (ITBS). Youth and Family Center mean scores were lower than overall District mean scores for both ITBS and TAAS. When the District's Student Effectiveness Indices were calculated and concomitant variables were controlled, students were at expectations on ITBS and TAAS.

Youth and Family Centers: Evaluation of an Integrated School-Based Health Care Program

Introduction

Through Title XI, P.L.-103-382 of the Elementary and Secondary Education Act, as amended by the Improving America's Schools Act of 1994, the Dallas Public Schools could redirect up to 5% of each appropriation received through the Act for the purpose of providing a comprehensive approach to meeting the educational, health, social service, and other needs of children and their families. As a result, the District's Office of Interagency Collaboration officially partnered with the Dallas County Mental Health Mental Retardation (MHMR) Child and Adolescent Services as well as the Dallas County Hospital District's Community Oriented Primary Care (COPC) to provide services at nine Youth and Family Centers. An integrated service delivery model was chosen to provide coordinated, collaborative physical health, mental health, and other support services.

History

It is important to understand the philosophy underlying school-linked services to understand the premise upon which the Youth and Family Centers were operated. According to the advocates of school-linked services, the school becomes the "hub" or link between education, health, social services, and other support services that children and families need. Additionally, children's physical and emotional well-being are approached holistically (Shaw, 1995). As Sharon Robinson, Assistant Secretary for Educational Research and Improvement, remarked at a working conference related to school-linked comprehensive services in 1994,

> the time has come to reach across self-created divides and focus on the whole child and the whole family and the whole community . . . Most often the school is the hub or, at least, one necessary component. Not only is this a more efficient way of delivering services, but it also affirms that children are a part of families and families are a part of communities (American Association of Colleges for Teacher Education et. al., 1995).

According to Koppich and Kirst, children under the age of 18 account for 40% of America's poor. In the Dallas Public Schools, over 70% of the students are economically disadvantaged. As a result of poverty, "large numbers of American children have inadequate health care, never see a dentist, and are left to care for themselves for long

hours while their parents are at work. Many others tangle with the juvenile justice system or come from abusive homes." Koppich and Kirst point out that there is a large amount of child- and family-oriented policy at all levels of government. However, there have been problems with the multi-agency system. First, many children are underserved and slip through the cracks. Second, most governmental agencies operate under a triage approach where the most severe problems are treated with little emphasis placed on prevention. Third, due to complicated regulations of bureaucracies, service for families is often fragmented. "Families are forced to tell their life stories over and over to differing sets of agency representatives as they seek themselves to cobble together a package of services" (Koppich and Kirst, 1993). Fourth, due to each entity providing specialized services, comprehensive solutions often are not found for complex problems (Larson, et. al., 1992; Koppich and Kirst, 1993).

Although many have questioned the school's role in meeting children's needs other than education, "any teacher or administrator knows that a child who comes to school hungry or ill or abused simply cannot learn as effectively as a child who enters the classroom free of these debilitating conditions" (Koppich and Kirst, 1993). As a result, the issue has been how to make needed services available and accessible. Proponents for school-linked services feel that schools are the best place to integrate services that children need for success. Specifically, schools provide the most sustained contact with children, and schools have little stigma attached to them compared to other social service agencies.

The District has been on the cutting edge of school-based health care for over 20 years. However, the efforts of the District have been varied, fragmented, and uncoordinated since there has been no single entity to address the overall well-being of children and families and since services have not been available in all areas of the District. The purpose of the Youth and Family Centers has been to offer students and their families acceptable and accessible physical health care, mental health care, and other services as needed. All of the previously existing entities co-located to offer combined health, mental health, and other support services. As a result, students and families have benefited from one-stop shopping to meet their multiple needs.

PURPOSE AND SCOPE OF THE EVALUATION

The purpose of the evaluation was to determine the services provided, the administrative system used to coordinate the various services, how the program was implemented, the perceptions of principals and families who received the services, and the relationship between services and related outcome measures. This paper has been limited to the following evaluation questions:

1. What were the characteristics of the students and families served?
2. What services were received?
3. How did principals and families respond to the school-linked services?
4. Did students show improved attendance, grades, and behavior?
5. Did students improve their scores on Districtwide achievement measures in comparison to the previous year?

Services Provided

A brief description of the services provided through the Youth and Family Centers follows.

Physical Health. Physical health services included health maintenance exams, urgent care, immunizations, sports physicals, medication, nutrition counseling, lab work, episodic care, and chronic disease management. In most cases, students were referred through the school nurse for these services. Parents were encouraged to accompany their children for visits, if feasible. Once students were referred to the clinic, a family history and medical evaluation were completed. Next, a collaborative treatment plan was developed, and the student received medical intervention, follow-up, and medication, if appropriate. Some students were placed in support groups or referred for a mental health evaluation. The clinic staff followed up with the school nurse.

Mental Health. Mental health services included family therapy, student therapy, group therapy, student support groups, family support groups, psychiatric evaluation, parent support groups, parent education classes, student social skills classes, medication, and classroom behavior plans. Students were to be referred for mental health services through campus Student Support Teams (SST). Parents were required to accompany their child to the Youth and Family Center for mental health referrals. Upon referral to the

center, a psychiatric evaluation was completed along with a Collaborative Treatment Plan and a School Service Plan. Clinic follow up included individual, family, or group therapy; medical evaluation and intervention; medication, if appropriate; and other auxiliary services. The SSTs were to review and follow up on the School Service Plan.

Other Support Services. Other support services available through the Youth and Family Centers included the Family Youth/Interaction (FYI) Program, Legal Advocacy for Minors Project (LAMP), Adult Basic Education (ABE), after school activities, and recreational activities. FYI, a six week social and life skills training course for parents and at-risk students in Grades 4 through 12, covers topics related to self-responsibility, self-esteem, decision-making, goal setting, and communication skills. Through LAMP, legal advocates and mentors were assigned to students charged with non-violent crimes upon physical, psychological, and educational assessment at the centers. LAMP is sponsored by the Dallas Bar Association and the Dallas County Juvenile Department. ABE included General Educational Development (GED) and English-as-a-Second-Language (ESL) instruction.

Emergency and crisis intervention. All students and families had access to 24-hour emergency and crisis intervention through MHMR and COPC. The site managers were responsible for the continuum of care.

MAJOR EVALUATION RESULTS

What were the characteristics of the students and families served?

Methodology

Each center clerk entered information into a data base developed by the Department of Research and Evaluation. Information included student and family demographics, presenting problems, diagnoses, and services received. Data were analyzed overall and for each center separately to determine the variation in caseloads between the centers. Additionally, in some cases, data were analyzed by initial service received.

Results

In all, 3,407 students, 14 parents, and 1 other family member received services through the Youth and Family Centers. Case loads varied from 57 at one site to 1,077 persons at another site. Some of the differences in volume were due to varying levels of

implementation at the centers. The majority of students (87%) initially received physical health services; 12% initially received mental health services, and less than 1% initially received support services. As for special programs, 2,299 (68%) of the students were in Title I, 135 (4%) were in Special Education, and 397 (12%) were in Bilingual Education.

The gender, ethnicity, and grade levels of the students served is shown in Table 1. There were more females (N=1,788; 53%) than males (N=1,618; 47%). Approximately half of the students (51%) were Hispanic. Additionally, 32% were African American, and 15% were Anglo. As for grade level, the largest percentages were for 8th (12%) and 9th (18%) grade. The number of students served peaked between the 5th and 10th grades.

When studied by initial service received, there were 36% more males than females referred for mental health, whereas there were 12% more females than males referred for physical health. There were four more males than females initially referred for support services. When reviewed by ethnicity, the percentages of African American, Hispanic, and Anglo students referred initially for mental health were 44%, 33%, and 21%, respectively. As for physical health, over half (53%) were Hispanic. Additionally, 31% were African American, and 14% were Anglo. All of the students initially referred for support services (N=9) were Hispanic.

When studied by grade level, it was interesting to note that 40% of the students initially referred for mental health services were in Grades pre-Kindergarten (PK) to 3. Another 23% were in Grades 4 to 6. Thus, 63% of those initially referred for mental health services were in the elementary grades. This is consistent with the staff's philosophy of helping students work through problems when they are young rather than waiting and allowing problems to escalate. Most of the students initially referred for physical health services were in high school (41%) or middle school (23%). All of the students initially referred for support services were between Grades 4 through 8.

Table 1

Student Demographic Information By Initial Service

Information	Mental Health N (%)	Physical Health N (%)	Support Services N (%)	Total N (%)
Gender				
Male	286 (69)	1,311 (44)	11 (61)	1,618 (47)
Female	126 (31)	1,648 (56)	7 (39)	1,788 (53)
Ethnicity				
Af. Amer.	181 (44)	910 (31)	0 (0)	1,097 (32)
Hispanic	134 (33)	1,577 (53)	9 (100)	1,728 (51)
N. Amer.	6 (1)	4 (<1)	0 (0)	10 (<1)
Anglo	85 (21)	406 (14)	0 (0)	492 (15)
Asian	2 (<1)	34 (<1)	0 (0)	38 (1)
Other	3 (1)	22 (1)	0 (0)	25 (1)
Grade				
PK	3 (1)	13 (<1)	0 (0)	16 (1)
K	29 (7)	168 (6)	0 (0)	200 (6)
1	44 (11)	117 (4)	0 (0)	164 (5)
2	42 (10)	100 (3)	0 (0)	143 (4)
3	44 (11)	83 (3)	0 (0)	128 (4)
4	35 (8)	98 (3)	1 (6)	134 (4)
5	38 (9)	114 (4)	1 (6)	153 (4)
6	26 (6)	237 (8)	3 (17)	266 (8)
7	36 (9)	285 (10)	1 (6)	325 (9)
8	33 (8)	379 (13)	3 (17)	416 (12)
9	40 (10)	564 (19)	0 (0)	606 (18)
10	19 (5)	287 (10)	0 (0)	306 (9)
11	10 (2)	200 (7)	0 (0)	210 (6)
12	9 (2)	166 (5)	0 (0)	175 (5)
Missing	4 (1)	148 (5)	9 (48)	164 (5)

What services were received?

Physical health. There were a total of 3,686 physical health visits. The visit types and diagnoses for the students who received physical health services are displayed in Table 2. Approximately half of the visits (49%) were acute visits. Another 23% were for immunizations. Additionally, 15% of the visits were for health maintenance, and 12% were follow-up visits. Almost two-thirds (64%) of the diagnoses were different from the overall categories included in the analysis. As a result, additional categories will need to be included for the 1996-97 school year. Additional diagnoses included upper respiratory

(7%), contraception (5%), middle ear infection (4%), asthma (3%), and allergic rhinitis (2%). Other diagnoses varied and were received by 1% or less of the students.

Table 2

Physical Health Visit Type and Diagnosis

Information	Total N (%)
Visit Type	
Acute visit	1,795 (49)
Immunizations	862 (23)
Health maintenance	534 (15)
Follow-up	446 (12)
Diagnosis	
Other	2,358 (64)
Upper respiratory	259 (7)
Contraception	191 (5)
Middle ear infection	133 (4)
Asthma	115 (3)
Allergic rhinitis	84 (2)
Stress	19 (1)
Cervicitis	49 (1)
Prenatal visit	2 (<1)
School problems	15 (<1)
Obesity	10 (<1)

Mental health. A total of 2,677 mental health visits were logged during the 1995-96 school year. The presenting problems, diagnoses, and treatments for those who received mental health services are displayed in Table 3. Behavior was the presenting problem for almost half (47%) of the students. Other presenting problems included emotional issues (29%), family issues (14%), health issues (6%), and academic problems (3%). There were 21 students (1%) who were required to receive mental health services due to a court order. Almost half (49%) of the diagnoses were missing. Of the remaining 51%, a variety of diagnoses were given including behavior disorders (16%) and mood disorders (15%). Treatments that were prescribed included individual therapy (34%), family therapy (24%), school interventions (20%), parent training (12%), medication (11%), support group (10%), group therapy (1%), and couples therapy (<1%).

Table 3

Mental Health Presenting Problems, Diagnoses, and Treatments

Information	Total N (%)
Presenting Problem	
Behavior	1,270 (47)
Emotional	775 (29)
Family issues	364 (14)
Health issues	154 (6)
Academic	88 (3)
Court ordered	21 (1)
Missing	5 (<1)
Diagnosis	
Missing	1,309 (49)
Behavior disorder	428 (16)
Mood disorder	392 (15)
Other	154 (6)
No mental disorder	100 (4)
Adjustment disorder	99 (4)
Anxiety disorder	120 (4)
V-Code	63 (2)
Mental retardation	3 (<1)
Personality disorder	4 (<1)
Psychotic disorder	4 (<1)
Somatization disorder	0 (0)
Treatment	
Individual therapy	907 (34)
Family therapy	653 (24)
School interventions	531 (20)
Parent training	323 (12)
Medication	294 (11)
Support group	267 (10)
Group therapy	27 (1)
Couples therapy	7 (<1)

Support Services. In all, 1,485 received support services through the centers. Over half (56%) attended FYI classes. Another 17% were involved in recreation services. Additionally, 1% received LAMP services, and 1% were involved in Adult Basic Education services. Another 25% received Other services. Of the 25%, 279 (19%) participated in the Power of Parenting (POP) program developed for parents with children between the ages of Kindergarten and third grade. Thus, 75% of the students attended life

skills courses through FYI and POP. Parent participation was required for both of these programs.

How did principals and families respond to the school-linked services?

Methodology

Information related to principal and family perceptions of the Youth and Family Centers were collected through questionnaires. Questionnaires were sent to all of the principals that had a Youth and Family Center in their high school cluster in April. Family Satisfaction Questionnaires were administered to a sample of families at each center at the end of the spring semester.

Results

Principal Survey. There were 75 principals from the nine high school clusters who completed the survey. Responses were tabulated separately for each of the nine centers. Since there were no significant differences in mean responses to the survey questions by center, the results will not be discussed separately for each center.

The first four questions were related to the level of awareness of the services provided through the centers. As seen in Table 4, the majority of principals reported that they definitely had received adequate information to understand the services (59%) as well as the procedures for referring students to the Youth and Family Center (57%). Most believed that teachers and other staff members were (49%) or definitely were (23%) aware of the services provided through the center. Over half felt that students and families were (44%) or definitely were (15%) aware of the services; however, a sizable portion were not sure (13%) or did not think (28%) that students and families were aware of the services.

Questions 5 through 7 were related to the principals' perceptions of the effects of the services on student attendance, student behavior, and student achievement. Although the majority of responses were positive overall, the responses to the three questions were not strongly positive. At the end of the survey, a few principals commented that it was too soon to tell if the services had positively affected these areas. As a result, this may be why these results were not strongly positive.

Table 4

Results of the Principal Survey

Question	Definitely Yes N (%)	Yes N (%)	Don't Know N (%)	No N (%)	Definitely No N (%)
1. Have you received adequate information to understand the services provided by the Youth and Family Center?	44 (59)	29 (39)	1 (1)	1 (1)	0 (0)
2. Have you received adequate information about the procedures for referring students and families to the Youth and Family Center?	43 (57)	29 (39)	2 (3)	1 (1)	0 (0)
3. Do you believe that teachers and other staff members are aware of the services provided through the Youth and Family Center?	17 (23)	37 (49)	9 (12)	12 (16)	0 (0)
4. Do you think that students and families are aware of the services provided through the Youth and Family Center?	11 (15)	33 (44)	10 (13)	21 (28)	0 (0)
5. Do you think that the Youth and Family Center has made a positive impact on student attendance at your school?	26 (35)	18 (24)	19 (25)	12 (16)	0 (0)
6. Do you think that the Youth and Family Center has made a positive impact on student behavior problems at your school?	23 (31)	31 (41)	15 (20)	6 (8)	0 (0)
7. Do you think that the Youth and Family Center has made a positive difference on student achievement at your school?	18 (24)	23 (31)	23 (31)	10 (14)	0 (0)
8. Do you think the Youth and Family Center staff provide quality services to students and families?	43 (57)	24 (32)	8 (11)	0 (0)	0 (0)
9. Would you recommend the addition of a Youth and Family Center to principals in other high school clusters?	53 (71)	22 (29)	0 (0)	0 (0)	0 (0)
10. Does the Youth and Family Center in your high school cluster have a positive reputation?	41 (55)	28 (38)	5 (7)	0 (0)	0 (0)
11. Overall, is the Youth and Family Center valuable to the students at your school?	47 (63)	25 (33)	3 (4)	0 (0)	0 (0)

The last four questions were related to the quality of the services, the reputation of the centers, and principals' perceptions of the value of the centers. In Question 8, principals were asked whether they thought that the center staff provided quality services to students and families. The majority of responses were strongly positive (57%) to this question. Another 32% responded with "yes" to this question, and 11% were unsure of the quality of services.

Principals were asked in Question 9 whether they would recommend the addition of a Youth and Family Center to other principals. All of the principals gave positive responses to this question with 71% answering "definitely yes" and the other 29% answering "yes". As for the center's reputation (Question 10), most of the principals responded that the center had (38%) or definitely had (55%) a positive reputation. All but three of the principals felt that the center was (33%) or definitely was (63%) valuable for the students at their school.

Principals gave varied answers to what they liked best. Principals were most pleased with the services provided (N=24), the accessibility of the centers to families (N=22), the center staff (N=15), and the quick services received (N=12). Six principals liked the centers' involvement and provision of services to the entire family. Four principals were glad that services were available, if needed, for their students and families. Other responses varied.

Principals were next asked what they liked least about the Youth and Family Centers. Seven principals felt that the location of the center was a problem since some families had no transportation. Two of the seven principals wished that they had a center at their school campus. Another five principals reported that more clinic time was needed for the families. Three of the five principals were concerned that students had to be on a waiting list for mental health services. Four principals felt that there were more students that needed help than there were personnel. Three principals were disappointed by the lack of feedback to their campus once students had been referred. Another three principals felt that the centers needed to provide additional help for completing intakes on the families. Other responses varied.

Principals offered a variety of suggestions for the improvement of the centers. Eighteen principals suggested that there be more publicity and better dissemination of information to families and school personnel concerning the services being offered through the centers. Specific suggestions included presentations at faculty meetings, School-Centered Education (SCE) committee meetings, Parent Teacher Association (PTA) meetings, school staff development sessions, and community groups. Suggestions given by two or more principals included additional mental health time (N=9), more campus involvement with teachers and parents (N=9), better communication with the referring campus (N=7), more personnel to meet family needs (N=5), more centers (N=5), transportation provisions (N=3), expansion of service hours (N=2), expansion of services to more students and families (N=2), and more equipment and supplies in the centers (N=2). A variety of other responses were given as well.

In summary, the responses of the principals were positive. Principals clearly felt that they had received adequate information about the centers. Principal perceptions of the effects of the services were positive, but not strongly positive. Most principals strongly felt that the staff provided quality services, that the centers had a positive reputation, and that the center was valuable to their students. Additionally, the majority of principals responded that they definitely would recommend the addition of a Youth and Family Center to other principals who did not have a center. Principals most liked the services, the accessibility of the centers, the staff, and the promptness of the centers in providing intakes and services to the students. Lack of transportation, students being on a waiting list for services, and shortage of personnel were what principals least liked. A common suggestion for improvement was increased publicity of the services to school staff members, families, and the community.

Family Satisfaction Survey. A sample of parents from each of the nine centers was asked to complete a Family Satisfaction Questionnaire. In all, 273 persons responded to the questionnaire. The majority of respondents (N=171; 63%) were mothers. Another 9% were fathers, and 20% were other family members related to the student. The question was left blank by 8% of the respondents.

Overall, the responses were strongly positive. The first two questions were related to the families' perceptions of the services and the amount of time the staff spent with them. As can be seen in Table 5, 94% reported that they were happy (44%) or very happy (50%) with the services. Additionally, 91% said that they were happy (41%) or very happy (50%) with the amount of time the Youth and Family staff spent with them.

The next two questions were related to the families' satisfaction with the staff person who worked with them. Ninety-one percent felt that the staff person who worked with their family was helpful (31%) or very helpful (66%). All but one respondent reported that the staff person was nice to them always (88%) or most of the time (11%).

In Question 5, the families were asked how involved they had been in their child's evaluation and follow-up. Sixty-six percent of the respondents were always involved, and 28% were involved most of the time. There were 17 parents (6%) who reported that they were not highly involved in their child's evaluation and follow-up.

Families were asked in Question 6 how much they had learned about their child's or family's problems since coming to the Youth and Family Center. Half of the parents reported that they had learned a lot. Additionally, 28% said that they had learned much, and 14% believed that they had learned a fair amount. The other 8% did not feel that they had learned much, if anything, since coming to the center.

Questions 7 through 9 were related to the progress of the child and family since coming to the Youth and Family Center. Although positive, the responses to these questions were not strongly positive. Most of the parents reported that their child was doing better (46%) or much better (39%) since coming to the Youth and Family Center. Similarly, the majority of respondents felt that the program had helped them deal with their problems better (46%) or much better (35%). Most parents were happy (44%) or very happy (42%) with the progress made by their child or family.

Question 10 dealt with problems that hindered families from receiving help through the Youth and Family Center. The majority (82%) said that nothing got in the way. There were a few families who felt that transportation (9%) and scheduling (6%) were sometimes problematic. Very few families (1%) reported language, culture differences, or location of the center as being barriers to their getting help at the center.

Table 5

Results of the Family Satisfaction Questionnaire

Question/Responses	N	%
1. How do you feel about the services?		
Very happy	135	50
Happy	119	44
Mixed	16	6
Unhappy	1	<1
Very unhappy	1	<1
2. How happy were you with the amount of time the Youth and Family Center staff spent with you?		
Very happy	136	50
Happy	113	41
Mixed	22	8
Unhappy	2	1
Very unhappy	0	0
3. The staff person who worked with your family was		
Very helpful	177	66
Helpful	83	31
Sometimes helpful	7	3
Not helpful	1	<1
Made things worse	1	<1
4. Was the staff person nice to you?		
Always	240	88
Most of the time	31	11
Sometimes	0	0
Rarely	1	<1
Never	0	0
5. How much did you take part in your child's evaluation and follow-up?		
Always	171	66
Most of the time	71	28
Sometimes	6	2
Rarely	5	2
Never	6	2

Continued

(Table 5 Continued)

Question/Response	N	%
6. Since coming to the Youth and Family Center, how much did you learn about your child's and/or family's problems?		
A lot	132	50
Much	72	28
A fair amount	36	14
A little	14	5
Nothing	9	3
7. Since coming to the Youth and Family Center, how is your child doing?		
Much better	97	39
Better	112	46
About the same	34	14
Worse	3	1
Much worse	0	0
8. The program has helped you deal with your child's/family's problems...		
Much better	87	35
Better	116	46
About the same	45	18
Worse	2	1
Much worse	0	0
9. How happy are you with the progress made by your child/family?		
Very happy	104	42
Happy	110	44
Mixed	36	14
Unhappy	0	0
Very unhappy	0	0
10. What things got in the way with you and/or your family getting help at the Youth and Family Center?		
Nothing got in the way	201	82
Transportation problems	21	9
Language	3	1
Culture differences	2	1
Location of center	2	1
Scheduling	15	6

Continued

(Table 5 Continued)

Question/Response	N	%
11. If your family has the same problem again, would you come back?		
Definitely yes	144	58
Yes	85	34
Maybe	16	6
No	4	2
Definitely no	0	0

Last, families were asked if they would return to the center if they had the same problem again. The majority of families reported that they would (34%) or definitely would (58%) return if the problem recurred.

In summary, responses were strongly positive to the Family Satisfaction Questionnaire. The majority of families were clearly pleased with the services, staff, and knowledge that they had gained related to their families' problems. Additionally, most were involved in their child's evaluation and follow-up. Although not strongly positive, most families were pleased with the progress made by their child or family. It was encouraging to note that the majority of families would definitely return to the center if they had the same problem again.

Did students show improved attendance, grades, and behavior?

Methodology

Data related to student attendance, grades, behavior, and nurse visits were gathered the second six weeks and last six weeks of the 1995-96 school year for students who received services. The center managers and clerks collected the information and entered it into the data base. Frequencies of fall and spring measures were calculated to note whether there were decreases from the beginning to the end of the school year. Next, McNemar chi square (χ^2) tests were calculated for the four indices to note if there were statistically significant differences from fall to spring. Last, effect sizes (Cohen's w) were calculated to note whether the results were of practical significance.

Results

As seen in Table 6, there were decreased discipline referrals, course failures, absences, and nurse visits from the beginning of the school year to the end. For example, there was a 17% decrease in the number of students who had three or more discipline referrals from fall to spring. Similarly, there was a 15% decrease in the number of students who had two or more failures from the beginning to the end of the year. As for attendance, there was a 21% decrease in the number of persons who had three or more absences from fall to spring, and a 15% decrease in the number of students who had three or more nurse visits from the beginning to the end of the school year.

Table 6

Student Attendance, Grades, Behavior, and Nurse Visits

Information	2nd 6 Weeks N (%)	Last 6 Weeks N (%)	χ^2	w
Behavior				
3 or more discipline referrals	426 (29)	173 (12)		
Less than 3 discipline referrals	1,064 (71)	1,317 (88)	161.59*	.25
Grades				
2 or more failures	509 (33)	285 (18)		
Less than 2 failures	1,043 (67)	1,267 (82)	107.17*	.25
Attendance				
3 or more absences	800 (48)	444 (27)		
2 or fewer absences	866 (52)	1,222 (73)	196.91*	.22
Nurse visits				
3 or more visits	620 (34)	353 (19)		
2 or fewer visits	1,211 (66)	1,478 (81)	120.53*	.20

Note. * $p<.00001$, w=effect size. Effect sizes of .10, .30, and .50 are considered small, medium, and large, respectively.

To note whether the decreases were statistically significant, χ^2's were calculated for the four sets of measures. In all cases, the χ^2's were statistically significant. Since χ^2's are affected by sample size, effect sizes were calculated to note practical significance. When rounded, effect sizes for behavior and grades were considered medium. In the other two cases, the effect sizes were considered small (Cohen, 1988). Although there were

medium effect sizes for behavior and grades, the results should be reviewed with caution since there was no control group.

Next, the four pre and post measures were compared by the students' initial service. (See Table 7.) The most noticeable percentage decreases were in discipline referrals (42%) and course failures (31%) for those initially referred for mental health services. There were approximately one-fifth fewer students who had three or more absences from fall to spring for both mental health (22%) and physical health (21%) initial referrals. The decrease in number of nurse visits was 18% and 15% for students initially referred for mental health and physical health services, respectively. For students initially referred for physical health services, there was a decrease of 11% in the number of students who had three or more discipline referrals as well as in the number of students who had two or more failures. As for support services, there were decreases in the number of discipline referrals and course grades. However, there was no change in number of absences and an increase in nurse visits. These percentages should be reviewed with caution since there were only six students who were initially referred for support services.

Next, χ^2's were calculated by initial service to note if there were statistically significant differences between the pre- and post rating categories for the four variables. The sample size of six was too small to calculate χ^2's for those who received support services. There were statistically significant differences between the four pre- and post measures for those who initially received both mental and physical health services. Next, effect sizes were calculated to note the practical significance. When rounded, the physical health effect sizes were considered medium for behavior, grades, and attendance. All of the other effect sizes were considered small (Cohen, 1988). Once again, the results should be viewed with caution since no control group was utilized.

In summary, students referred to the Youth and Family Centers during the 1995-96 school year had fewer discipline referrals, course failures, absences, and nurse visits from the beginning to the end of the school year. Considering that the data are preliminary and from a start-up year, the results are encouraging. Unfortunately, the analysis was limited since the actual numbers of discipline referrals, failures, absences, and

nurse visits were not collected. It is suggested that the actual numbers be collected in the future.

Table 7

Student Attendance, Grades, Behavior, and Nurse Visits By Initial Service

Information	Mental Health		Physical Health		Support Services	
	2nd 6 Weeks N (%)	Last 6 Weeks N (%)	2nd 6 Weeks N (%)	Last 6 Weeks N (%)	2nd 6 Weeks N (%)	Last 6 Weeks N (%)
Behavior						
3 or more discipline referrals	179 (63)	59 (21)	245 (20)	112 (9)	1 (17)	0 (0)
Less than 3 discipline referrals	106 (37)	226 (79)	952 (80)	1,085 (91)	5 (83)	6 (100)
χ^2		91.95*		73.51*		NA
w		.10		.25		NA
Grades						
2 or more failures	150 (54)	64 (23)	354 (28)	215 (17)	4 (67)	5 (83)
Less than 2 failures	128 (46)	214 (77)	912 (72)	1,051 (83)	2 (33)	1 (17)
χ^2		55.58*		57.53*		NA
w		.10		.27		NA
Attendance						
3 or more absences	139 (49)	75 (27)	658 (48)	367 (27)	2 (33)	2 (33)
2 or fewer absences	144 (51)	208 (73)	717 (52)	1,008 (73)	4 (67)	4 (67)
χ^2		30.53*		166.53*		NA
w		.10		.27		NA
Nurse visits						
3 or more visits	112 (40)	63 (22)	504 (33)	285 (18)	3 (50)	4 (67)
2 or fewer visits	171 (60)	220 (78)	1,035 (67)	1,254 (82)	3 (50)	2 (33)
χ^2		22.37*		98.80*		NA
w		.17		.20		NA

Note. NA=Not Applicable, *=p<.0001, w=effect size. Effect sizes of .10, .30, and .50 are considered small, medium, and large, respectively.

Did students improve their scores on Districtwide achievement measures in comparison to the previous year?

Methodology

The evaluator reviewed Iowa Test of Basic Skills (ITBS), Spanish Assessment of Basic Education (SABE), and Texas Assessment of Academic Skills (TAAS) as well as the District's Student Effectiveness Indices (SEI) for all students who received services through the Youth and Family Centers. All of the test data were extracted from the

District data base and analyzed by subtest. There were very few students who had scores for the SABE. As a result, analysis was not conducted on these scores.

ITBS. The 1994-95 spring test scores were used as a pretest measure, and the 1995-96 spring test scores were used as a posttest measure. Normal Curve Equivalent (NCE) scores were used in the analysis. ITBS reading and mathematics scores were available for students in Grades 1 to 9.

TAAS. TAAS reading and mathematics passing rates and Texas Learning Index (TLI) scores were reviewed for 1995 and 1996. TLI scores indicate how far performance is in comparison to the passing standard which is a TLI of 70. TLI scores also show whether students demonstrated a year's worth of progress. For example, if a student had a TLI of 72 one year and the next year had a score of 81, more than a year's progress was made. TAAS scores were available for students in Grades 3 to 8.

SEI. The District's Student Effectiveness Indices (SEI) were reviewed for ITBS/SABE reading and mathematics and for TAAS reading and mathematics. Student Effectiveness Indices (SEI) are computed utilizing both multiple linear regression and hierarchical linear modeling. The result is a "value-added" effectiveness model. To determine program effectiveness in value added terms, an outcome on an achievement measure is predicted for each student based on a given set of student characteristics as well as the student's previous level of performance on a related measure. Next, the difference between the student's actual and predicted score on the achievement measure is calculated. Last, the magnitude of the aggregated program data is computed to note whether performance exceeds or falls below expected performance (Mendro, Webster, Bembry, & Orsak, 1995).

The effectiveness model has two stages: a residualizing stage and a final prediction stage. In the first stage, predictor and outcome variables at each grade level are regressed on a group of variables and the first and second order interactions of the variables. Variables include a combined ethnicity/language proficiency variable, gender, lunch status, school-level mobility, school overcrowdedness as well as block-level family income, education level, and poverty (Webster, Mendro, Bembry, & Orsak, 1995). At

each grade level, difference scores between predicted and actual values are predicted for each predictor and outcome variable.

In the final prediction stage, residuals of the predictor variables are used to predict residuals of the outcome variables by regressing outcome residuals on the residualized predictor variables (Webster, et. al., 1995). Next, the raw residuals (computed by subtracting the predicted outcome residuals from the actual outcome residuals) are standardized within 256 predictor-space intervals and converted to scores with a mean of 50 and a standard deviation of 1.

Results

ITBS. Gain scores, calculated by subtracting each students' posttest score from his or her pretest score, were used to note whether students made positive or negative gains from the previous school year. No reading (45%) or mathematics (43%) scores were available for a large portion of students. Thus, the results are limited and may not be truly representative of all of the students who received services. As seen in Table 8, overall, students who received services at the centers had a -2.38 gain in reading scores and a -1.64 gain in mathematics scores. When the scores were calculated for those initially referred for mental and physical health services separately, there were also negative gains on both the reading and mathematics tests. The mean scores for the ITBS reading and mathematics scores for the District overall for the 1995-96 school year were 44.1 and 48.0, respectively, in contrast to the Youth and Family Center means of 38.6 and 43.7 for the two tests. It is evident that the students who were referred to the Youth and Family Centers had lower mean scores on both of these tests than the District overall. Also of interest is that overall, students in the District had a negative gain of -1.4 on the reading test and a positive gain of 0.5 for the mathematics test. In contrast, the negative gains of -2.38 and -1.64 for reading and mathematics received by center students were somewhat lower than the District overall. Thus, from 1995 to 1996, the center students had lower scores and larger negative gains from the previous school year on the ITBS than the District overall. In summary, students did not make positive gains on the ITBS as hoped. Since this has been a start-up year for the centers and since most centers did not

offer services until the end of November, it is probably too soon to see noticeable gains on standardized test scores.

Table 8

ITBS Mean NCE Gain Scores

Group	No. of Students	Pretest M	Pretest SD	Posttest M	Posttest SD	M Gain
		Reading				
All	1,042	41.00	19.27	38.62	19.71	-2.38
Mental Health	141	39.78	19.51	37.62	18.81	-2.16
Physical Health	889	41.32	19.28	38.97	19.88	-2.35
District	73,170	45.50	19.10	44.10	18.80	-1.40
		Mathematics				
All	1,012	45.30	20.32	43.66	21.10	-1.64
Mental Health	160	42.30	22.70	41.58	21.35	-0.72
Physical Health	841	46.01	19.81	44.18	21.07	-1.83
District	71,491	47.50	19.80	48.00	20.20	0.50

TAAS. A comparison of students who passed the reading and mathematics portions of the TAAS test for the 1994-95 and 1995-96 school years is displayed in Table 9. Approximately 33% of the students had no TAAS reading or mathematics scores available. The percentage of students who passed are shown for all of the students and for those initially referred for mental and physical health services. Additionally, the percentage of students passing the tests Districtwide are shown. Overall, for all center students and for those initially referred for physical health, there was a 2% increase in the number of students who passed the TAAS Reading test, and a 4% increase in the number who passed the TAAS Mathematics test. As for mental health, there was a 1% decrease in the number who passed the reading portion and a 10% increase in the number who passed the mathematics portion. The magnitude of the increase in pass rates on the reading test were close for the center students and District as a whole. However, for mathematics, the overall Districtwide increase (10%) was noticeably higher than the center students' increase (4%). It should be noted that the passing rates of the students who received services at the Youth and Family Centers were considerably lower than the

overall passing rates for the District. For example, 25% of the Youth and Family students passed the reading test in 1996, whereas 66% of the District students passed the test.

Table 9

TAAS Passing Rates for the 1994-95 and 1995-96 School Years

	Reading			Mathematics		
		% Passing			% Passing	
Group	N	S95	S96	N	S95	S96
All	466	23	25	463	13	17
Mental Health	67	19	18	65	12	22
Physical Health	391	24	26	389	13	17
District*	53,029	62	66	53,112	49	59

Note. S95=Spring 1995, S96=Spring 1996, *=Number of students who took the 1996 reading and mathematics tests.

In addition to pass rates, growth on the TAAS Texas Learning Index (TLI) were compared for the reading and mathematics tests to note the magnitude of improvement from the 1994-95 and 1995-96 school years. One-tailed paired sample *t*-tests were calculated to determine if increases in TLI scores were statistically significant. Additionally, effect sizes were calculated to note practical significance. The *t*-tests and effect sizes were tabulated for all of the students who received services through the Youth and Family Centers and separately for those who were initially referred for physical and mental health services. (See Table 10.) The results of the *t*-tests were statistically significant in all cases except for mental health reading. However, all of the effect sizes were considered small (Cohen, 1988). Thus, although there were increases in all cases from one year to the next, the results were not of practical significance. However, as mentioned above, no major gains were expected in test scores since most of the centers did not begin operation until the end of November. Rather, the review of test scores will serve as baseline data for future data analysis.

Table 10

Paired *t*-Test Results for TAAS Texas Learning Index (TLI)

Test	No. of Students	1995 M	1995 SD	1996 M	1996 SD	*t* Value	Critical Value	Effect Size
All Students								
Reading	466	72.12	16.20	73.97	16.59	3.14	1.65	.11
Mathematics	463	65.67	17.20	68.98	16.29	6.80	1.65	.20
Mental Health								
Reading	67	69.81	16.66	70.75	15.53	0.53	1.67	.06
Mathematics	65	61.51	18.93	65.72	16.94	2.72	1.67	.23
Physical Health								
Reading	391	72.62	16.21	74.86	16.64	3.59	1.65	.14
Mathematics	389	66.57	16.88	69.74	16.12	6.14	1.65	.20

Note. The 1-tail critical *t* value was used to compare the computed *t* statistic. A statistically significant difference exists if the computed *t* statistic is greater than the critical *t* value. Cohen's d was used to compare effect size. Effect sizes of .2, .5, and .8 are considered to be small, medium, and large, respectively (Cohen, 1988).

SEI. To study Youth and Family Center program effectiveness, effectiveness scores were aggregated for the Iowa Test of Basic Skills (ITBS) and the Texas Assessment of Academic Skills (TAAS). Effectiveness scores were calculated for all students and by initial service for the reading and mathematics portions of the two tests. By using the standard error of the mean to extend a 95% confidence interval around each aggregated effectiveness score, it was determined whether students were "at expectations," "above expectations," or "below expectations." Participants were labeled "at expectations" when the interval included 50. When the bottom of the interval did not reach down to 50, participants were considered "above expectations," and when the top of the interval did not reach up to 50, participant performance was labeled "below expectations."

Results of the 1995-96 student effective indices on the ITBS and TAAS tests are shown in Table 11. Included in the table are the number of students for which scores were available and the mean residual scores for all students as well as those initially referred for mental and physical health services. In all cases, when confidence intervals were

calculated, 50 was in the interval. Therefore, all students were at expectations. Thus, the Youth and Family Centers did not significantly add to the achievement of students who received services during the 1995-96 school year. It is interesting to note that although students' scores on ITBS and TAAS were lower than the District overall (See Tables 8 and 9), when concomitant variables were controlled, student progress was at expectations. Certainly it is hoped that as school performance barriers are decreased through Youth and Family Center services, that students' achievement scores will improve and that the gap between District and center students' scores will decrease. As mentioned earlier, all achievement data is preliminary and will serve as baseline data for the 1996-97 school year.

Table 11

Student Effectiveness Indices for Standardized Tests Given to Students Who Received Services at the Youth and Family Centers

	Mental Health			Physical Health			All Students		
Test	N	Score	Expec.	N	Score	Expec.	N	Score	Expec.
ITBS									
Reading	106	50.02	=	511	49.96	=	626	49.96	=
Mathematics	105	49.93	=	477	50.02	=	591	50.00	=
TAAS									
Reading	77	49.86	=	421	50.00	=	506	49.96	=
Mathematics	75	49.80	=	422	50.02	=	505	49.99	=

Note. Score=Effectiveness score with a mean of 50 and a standard deviation of 1. Expec.=Predicted expectation performance within two standard errors of the mean or a 95% confidence interval. "+" = above expectations. "-" = below expectations. "=" = at expectations.

In summary, students showed improvement on the TAAS, but negative gains on the ITBS reading and mathematics tests. Scores on the tests were lower than those of the District overall. When Student Effectiveness Indices were calculated, students were at expectations on the ITBS and TAAS tests.

CONCLUSIONS AND RECOMMENDATIONS

Outcome results for the first year of implementation were positive overall. Questionnaire responses were positive from principals and strongly positive from parents and other family members. The reductions in discipline referrals, course failures, absences, and nurse visits were promising. Results of standardized tests were not expected to show improvement due to the short time that the centers have been open. Rather, data will serve as baseline information for future years of implementation.

Recommendations

1. Diagnoses were labeled as "other" for 64% of the physical health visits and were missing for 49% of the mental health visits. The Partners and Operation Development Committee need to continue working through data sharing and confidentiality issues to ensure that data collection is meaningful and helpful to all entities.

2. Results of the principal surveys showed that several administrators felt that families and school personnel could benefit from more publicity and better dissemination of information related to services offered through the centers. Youth and Family Center managers and specialists should make a concerted effort to increase the number of contacts and presentations made to school staff members, parents, and community leaders.

3. Results of data analysis based on attendance, discipline referrals, course failures, and nurse visits were limited since the data were collected categorically and since the magnitude of improvement from one category to the next was unknown. It would be preferable to collect actual numbers of absences, discipline referrals, course failures, and nurse visits. As a result, more powerful data analysis could be done, and the magnitude of decreases or increases could be assessed.

4. During the 1995-96 school year, feedback was obtained from principals and from family members of students who received services. However, no information was received from students or from school staff members such as teachers or counselors. Information related to student and school staff member perceptions of center services should be collected during the 1996-97 school year. Additionally, information related to the quality of feedback between center staff members and teachers of students who received services at the centers should be gathered.

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